Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-15-0500-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 6, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 05/09/2014 we submitted our claims for payment to Texas Mutual in the amount of $519.47 via fax#512-224-3889. We received a partial payment of $17.57 on 5/09/2014, stating Worker's compensation jurisdictional fee schedule adjustment, and this charge was reimbursed in accordance to the Texas Medical Fee Guide line… Texas Work Compensation claim are to be reimbursed 125% of the Medicare allowable. Per Medicare guidelines, CGS DME MAC Jurisdiction C, 2nd quarter 2014, E0217 RR is supposed to be reimbursed at $60.44 per unit x 125%."

Amount in Dispute: $511.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual based its payment on the ceiling level for E0217RR, which is $60.44. Multiply this by 1.25 to get $75.77. Divide that amount by 30 days to get a per diem of $2.52. Multiply that by 7 units and the result is $17.64. No additional payment is due.

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2014	E0217	$511.28	$57.98

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
   - 891 - No additional payment after reconsideration

Issues

1. What is the applicable rule that determines the applicable fee guideline?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.203(b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The carrier alleges that HCPCS code E0217 should be paid at a daily rate, for a seven day rental period. According to the *Medicare Pricing, Data Analysis and Coding* contractor, www.dmepdac.com, this code is listed as "Inexpensive and routinely purchased."

   Per the Centers for Medicare/Medicaid Claims Processing Manual, www.cms.hhs.gov, Chapter 20, items in this category may be billed as follows: "30.1 - Inexpensive or Other Routinely Purchased DME (Rev. 1, 10-01-03), For this type of equipment, contractors pay for rentals or lump-sum purchases. However, with the exception of TENS (see 30.1.2), the total payment amount may not exceed the actual charge or the fee schedule amount for purchase." Also found in the Medicare Claims Processing Manual, Chapter 20, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies 130.8 - Installment Payments (Rev. 1, 10-01-03), "Where a beneficiary is purchasing an item through installments, the total price of the equipment item is reported on the first bill. Monthly payments are made (by the DMERC, carrier, FI or RHHI). The monthly amount is equivalent to the rental fee schedule amount and is paid until the fee schedule purchase price or actual charge has been reached, whichever comes first." The daily versus monthly rental is not applicable to this service. Therefore, the carrier's position of daily calculations is not supported.

   For the submitted code (E0217, RR), the carrier included remark code 790 – "This charge was reimbursed in accordance to the Texas Medical Fee Guideline." 28 Texas Administrative Code §134.203 (d) states in pertinent part, "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;…" Per the 2013 DMEPOS fee schedule, **https://www.dmepdac.com/dmecsapp/do/feesearch**, the maximum allowable reimbursement will be calculated as follows; the allowable amount $60.44 x 125% = $75.55.

   The total recommended payment for the services in dispute is $75.55. This amount less the amount previously paid by the insurance carrier of $17.57 leaves an amount due to the requestor of $57.98. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $57.98.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $57.98 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 29, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.